9.5016

REPORT

OF THE

TERTIARY CARE ADVISORY COMMITTEE

TO THE

MINISTER OF HEALTH & COMMUNITY SERVICES

CONCERNING

THE ESTABLISHMENT OF A CARDIAC SURGERY UNIT

IN

NEW BRUNSWICK

JANUARY, 1987

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INTRODUCTION

Following the receipt of a request by the Saint John Regional hospital to establish a cardiac surgery unit, the Minister of Health and Community Services requested the Tertiary Care Advisory Committee to consider the need for such a unit in the Province and to submit a report to her.

The Committee's terms of reference are:

A. To specifically define and recommend to the Department of Health and Community Services those diagnostic, treatment or rehabilitation services which should be considered as tertiary services.

B. To apply the following criteria as a guide to the development and placement of tertiary services in the Province: population (service volume and quality), language, physician and other personnel requirements and availability, specialized facilities, equipment, external service availability and cost.

C. To indicate the types of levels of expenditures that are associated with the development of each in-Province tertiary service.

D. To recommend relative priorities for development among various tertiary services and also in relation to other levels of service.

E. To conduct a continuing review of tertiary services in relation to the above terms of reference and to submit reports to the Minister of Health and Community Services as required.

F. To submit an annual report to the groups represented on the Committee.

The Committee commenced its discussions on November 6, 1985 and completed its task on January 19, 1987. In all, 6 meetings were held with information being provided by several sources, both from within the Province and external to the Province.

During this time requests were also received from The Moncton hospital and the Dr. Everett Chalmers hospital.

BACKGROUND

Throughout its deliberations the Committee received information from a variety of sources. Departmental support staff provided relevant data as well as a report on the joint visit by staff and the Saint John Regional to the Plains Health Centre in Regina, Saskatchewan and The General Hospital in Newfoundland.

The Department also presented a report on their visits to the Victoria General Hospital in Halifax, Nova Scotia, the Cardiac Institutes in Montreal and Laval, Quebec.

Presentations and briefs were received from the Saint John Regional hospital, The Moncton hospital, the Dr. Everett Chalmers hospital and Dr. Chandler who is the head of Cardiology at the Victoria General hospital.

At the January 12, 1987 meeting a brief was received from the New Brunswick Medical Society. As well, any information regarding this subject that was received by the Minister was distributed to the Committee.

DISCUSSIONS AND ACTIVITIES

The Committee's discussions and activities were centred around assessing the current situation and the implications of establishing a unit in the province.

Current Situation:

Cardiac surgery services are primarily provided to New Brunswick patients by the Victoria General Hospital in Halifax, Nova Scotia and the Cardiac Institutes in Montreal and Laval, Quebec. A few patients received services in Ontario.

Approximately 75-80% of services are provided by the Victoria General hospital and most of the remainder are provided by the Cardiac Institutes in Quebec. The Quebec hospitals provided services to the residents of the northern portion of the Province.

The questions arising from this review of the current situation were:

- is the quality of care satisfactory?
- are the services readily accessible?
- are New Brunswickers being underserviced?

Most members expressed the opinion that the quality of the service provided by these hospitals is excellent but there was some concern over the length of time that residents must wait for services. The departmental support staff were asked to gather some detailed information from the Victoria General regarding their waiting lists, mortality, priority of New Brunswick residents, etc.

This information was gathered and presented to the Committee. The Victoria General was very emphatic that they treated all patients from the Maritimes equally that is, patients were priorized according to clinical criteria and not their place of residence. At this point the discussion moved to the tenuousness of the present arrangements with these provinces. There was concern that at any time these hospitals could change their current practice without consultation. It was felt that before proceeding any further it would be valuable to know if these Provinces were willing to formalize the current arrangements and in the case of Halifax, to broaden the services to include more participation in the operation of the Centre.

The Committee then agreed to recommend to the Minister the following:

" The ultimate concern of the Tertiary Care Advisory Committee is that New Brunswick citizens have access to the best cardiac services available.
To that end, the Committee recommends that the Department of Health and Community Services, in consultation with the Committee:

a. Explore the feasibility of a Maritime Cardiac Surgery unit in Halifax.

b. Establish a formal working relationship with the Provinces of Nova Scotia and Quebec to ensure acceptable access to quality care for New Brunswick patients who wish to use those services.

In relation to the above, and not excluding other relevant issues, the following factors should be addressed:

i. Acceptable cost-sharing arrangements.

ii. New Brunswick participation in decision making regarding program development, management and delivery.

iii. Establishment of continuing education and of service outreach programs to ensure proper servicing of the population.

If it is not possible to establish working relationships that reflect these factors and allow New Brunswick patients access to required services, the establishment of a cardiac surgery unit in New Brunswick should be seriously considered."

In response to this recommendation, departmental support staff met with representatives from the Ministry of Health in both Provinces and representatives from the three hospitals and reported back to the Committee. The Province of Quebec stated that New Brunswick patients are not subject to longer waiting periods than Quebec residents and is willing to negotiate formal arrangements on the status quo. They also made a suggestion of guaranteeing beds.

The Province of Nova Scotia responded that they were willing to establish a Regional Heart Centre in Halifax with an Interprovincial Clinical Advisory Committee in Cardiac Care to advise on policies for the development and clinical operation of the Centre. All of these responses are included in the Appendices.

At the January 12, 1987 meeting Dr. Chandler, the Head of Cardiology at the Victoria General hospital came to give a presentation outlining their recent expansion and to answer questions. He believes that they are capable of handling the workload from New Brunswick without unacceptable waiting periods.

Implications of establishing a unit in the Province:

Expected Caseload:

The Committee tried to guesstimate what the caseload would be if a unit were established. The national average incidence of cardiac surgery requiring extracorporeal circulation was used as a base. This average is currently 45 to 50 cases per 100,000 population over the age of 15 years. However, it was pointed out that this could cause inaccuracies due to the fact that the incidence varies markedly between various provinces with British Columbia and Ontario being significantly higher than the other provinces.

Both the Saint John Regional and The Moncton hospital based their submissions on the assumption that the national average incidence would be achieved.

If it was assumed that the national average of incidence could be achieved then the population of New Brunswick could generate a caseload which though marginally below the national guidelines could be adequate to maintain an acceptable level of expertise. These guidelines referred to are the guidelines for Cardiovascular services in Hospitals published in 1985 by National Health and Welfare, Canada which state that:

> " A minimum viable cardiac surgery unit performing 4 to 6 procedures with cardiopulmonary bypass per week will require 2 qualified cardiac surgeons. Each cardiovascular surgeon should perform a minimum of 150 cases per year." (Section 5.1, p147)

It was acknowledged that there are Centres now operating in Canada that are below these guidelines. Upon further discussion it became obvious that the expected caseload would not only be dependent on the assumption of achieving the national average of incidence, but also on the established referral patterns and more importantly on the ability of the unit to provide completely bilingual services.

The necessity of bilingual services was recognized by all sources including the three hospitals and the New Brunswick Medical Society.

Cost Estimate:

The cost of a unit would depend on the caseload therefore it was difficult to arrive at an accurate cost estimate. However, it was agreed that there would be additional costs to the Province if a unit were established. This was attributed to two factors; first, under the present interprovincial cost sharing agreement for out-of-province hospital services, the cost of receiving cardiac services out of the province is somewhat lower than the cost of establishing and operating a unit in the Province. Secondly, until the unit achieves its optimal level of operation, the Province would still incur some costs of patients receiving services in other Provinces.

Underservicing:

It was felt by some members that New Brunswick is currently being underserviced and that a unit would have a significant impact on this. It was noted that the underservicing in the north was due in part to a lack of internists and cardiologists and this area of the province is also underserviced in many primary and secondary services.

Technological Developments:

The impact of the development and use of other procedures such as thrombolytic therapy and angioplasty was discussed and the opinions of surgeons such as Dr. Chandler and others was sought. It appears that the other procedures will not eliminate the need for a surgical unit but, it will reduce the number of bypass surgery operations necessary.

It was also noted that due to the high level of specialization the pediatric cases and transplant patients would continue to be referred out of the Province.

Waiting List:

It was difficult to say whether the waiting periods would improve substantially if a unit were established. The waiting lists from the Victoria General and the two Cardiac Institutes appeared to be comparable to other Centres. Moreover, a case could not be made for increased mortality due to waiting for non-urgent services.

Total Care vs Surgery:

There was much discussion on the fact that surgery is only one part of the total care necessary for cardiac patients. Equally

important are prevention and promotion, screening, and patient education and monitoring. It was felt that the presence of a cardiac surgery unit would have a positive effect on the development of these other aspects of care for the cardiac patients.

Priorities:

It was noted that establishing a unit would have implications on the development of other services and that it was the mandate of the Committee to consider the relative priorities among various tertiary services and also in relation to other levels of service. Therefore, the issue could not be considered in isolation from other issues. This point of view was also reflected in the brief from the New Brunswick Medical Society. This brief placed the following unanimous recommendation before the Committee:

> " The New Brunswick Medical Society approves in principle, the development of a cardiac tertiary service in New Brunswick. This approval is contingent upon the upgrading of primary and secondary services throughout the Province, particularly in under-serviced areas, and that the service be available in both official languages; and that current geographical referral patterns be a major consideration."

It was also the Society's view that " medical service development in this Province be considered from a global perspective. In this respect, it is their (our) view that a cardiac tertiary service be established but that primary and secondary care be enhanced in a complimentary fashion. Further, as evidenced in their(our) recommendation, the New Brunswick reality requires that this tertiary service be available in both official languages."

The committee then had to decide what was the relative priority of establishing a unit in the Province.

CONCLUSION

The committee, in its earlier meetings, considered the question of the clinical viability of a provincial cardiac surgical unit. It was agreed that the case load which could be expected would be adequate to maintain an acceptable level of expertise provided that referral patterns changed to accommodate the unit. This appeared to be accepted by most members, although there were some reservations about severing ties with excellent services available in neighboring provinces until the standards of the provincial Centre could be assessed. A further essential in attracting an adequate patient flow would be the availability of

a completely bilingual centre.

The Committee also reviewed the services presently available. It was agreed that these were of a very high standard but there was some concern over the waiting times for patients and the apparent tenuousness of these interprovincial relationships. As a result of the earlier recommendation regarding these agreements, these questions were explored by support staff.

Both the provinces and the surgical centres showed willingness to enter more formal agreements and indicated that they would be able to cop with the anticipated workload for at least five years.

Apart from the direct impact of the surgical unit, a number of members outlined other probable clinical benefits which would result from its establishment. Such benefits would encompass the encouragement of improved clinical services and perhaps the development of educational, preventive and promotional programs.

However, some members expressed concern about the availability of funds required in developing such a service, particularly referring to a number of letters received by the Minister and /or Chairman which raised the issue of the very serious regional disparities in provision of primary and secondary services.

This issue was also referred to in the brief from the New Brunswick Medical Society.

RECOMMENDATION

Owing to the strong concerns expressed with respect to the relative priorities for service development in the New Brunswick health system, the Committee was unable to reach a consensus on its recommendation. A revision of the earlier recommendation to the Minister was proposed and seconded. This motion read:

" The Committee has explored the feasibility of establishing formal working relationships with the Province of Nova Scotia (Maritime Cardiac Surgery Unit in Halifax) and the Province of Quebec, to ensure acceptable access to quality care for New Brunswick patients who wish to use those services.

In relation to the above, and not excluding other relevant issues, the following factors were considered:

1. Acceptable cost sharing arrangements.

2 New Brunswick participation in decision making regarding program development, management and delivery.

3. Establishment of continuing education and of service outreach programs to ensure proper servicing of the population.

Accordingly, the Tertiary Care Advisory Committee recommends to you that you proceed to establish these formal working relationships.

If upon further discussions it is not possible to establish these relationships to allow New Brunswick patients access to require services then, the establishment of a cardiac surgery unit in New Brunswick must be seriously considered."

This motion was carried by a marginal majority.

APPENDICES

APPENDIX A

Nova Scotia

Department of Health

Office of the Minister

PO Box 488
Halifax, Nova Scotia
B3J 2R8

October 6, 1986

NEW BRUNSWICK
RECEIVED
1986
MINISTER OF HEALTH
AND COMMUNITY SERVICES

Honourable Nancy Clark-Teed
Minister of Health and
Community Services
Province of New Brunswick
P.O. Box 6000
Fredericton, N.B.
E3B 5H1

Dear Hourable Minister:

I am responding further to your letter of June 6 and my letter response of July 2, 1986.

Discussions between officials of our respective departments and staff at the Victoria General Hospital in Halifax resulted in an agreement in principle to ensure that residents of New Brunswick who required cardiac surgery had access to quality care. I have instructed officials in my department and at the Victoria General to cooperate with your staff in developing a suitable arrangement.

I understand that the issue of costs for the particular supra-provincial programs - i.e. those specialty services provided in one province to meet the needs of residents in other provinces as well as locally - is being addressed by Health Departments across the country. It is a complex matter which may take some time to reach a conclusion. Without preempting the results of those discussions, I can assure you that any changes in the cost sharing arrangements will involve extensive discussions between the provinces and agreement on a way in which costs should be calculated. No doubt these discussions would form part of the participatory relationship suggested to ensure that New Brunswick has input into decision making concerning program development, management and delivery.

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Please do not hesitate to contact me if further assurances are required, or clarification is needed.

Yours very truly,

Ronald S. Russell, C.D.
Minister of Health

APPENDIX B

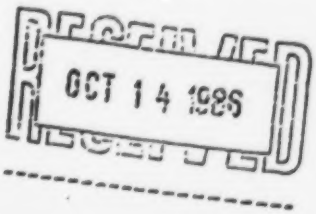
Nova Scotia

Victoria
General Hospital

1278 Tower Road
Halifax, Nova Scotia
B3H 2Y9

Our file no:

86 10 08



Dr. H. W. Wylie
Chief, Medical Division
Department of Health and
Community Services
P.O. Box 5100
Fredericton, New Brunswick
E3B 5G8

Dear Sir:

Further to our meeting of September 10, 1986 the following proposal addresses the provision of cardiac surgery for residents of New Brunswick:

1. A Regional Heart Centre is proposed for the Victoria General Hospital in Halifax. This Centre will provide tertiary cardiac services, including cardiac surgery to residents of New Brunswick, Prince Edward Island and Nova Scotia. Recent improvements in the cardiac facilities of the Victoria General include the expansion of our cardiac catheterization unit and an increase in the number of cardiovascular intensive care beds. These changes are part of a continuing plan to ensure the availability of high quality cardiac care for residents of the Maritimes.

2. An Interprovincial Clinical Advisory Committee on Cardiac Care is proposed. This committee should advise on policies for the development and clinical operation of the Centre. Membership should be jointly appointed by the provincial Departments of Health and should include government representatives, cardiac specialists and other concerned physicians from each of the Maritime Provinces. Representation from the Victoria General Hospital should include its Clinical Heads of Cardiology and Cardiovascular Surgery.

...../2

2. An Interprovincial Clinical Advisory Committee on Cardiac Care (Continued)

The mandate of the Committee should include formalization of admission criteria to ensure acceptable access to the Centre for all three provinces. In addition, the Committee should address the continuing education needs of health workers in the field of specialized cardiac care throughout the Maritimes.

As discussed at our meeting, the costing of cardiac surgery is currently being addressed by the Nova Scotia Department of Health. The results will be presented to the Atlantic Provinces Health Insurance Plans Directors for negotiation. This process will be a lengthy one and should therefore be considered separately from the proposed establishment of the Regional Heart Centre and Committee on Cardiac Care.

If the above meets with your approval, I would request that it be presented to the October meeting of the Tertiary Care Advisory Committee. Please advise me should you require any further discussion of the matter at this time.

Yours very truly,

R. L. Criddle
Executive Director

RLC/rt

APPENDIX C

RESPONSE TO QUESTIONS POSED BY TERTIARY CARE ADVISORY COMMITTEE, DEPARTMENT OF HEALTH, PROVINCE OF NEW BRUNSWICK REGARDING CARDIOLOGY/CARDIAC SURGERY AT THE VICTORIA GENERAL HOSPITAL

A) CAPACITY OF THE VICTORIA GENERAL HOSPITAL

1. Expansion of facilities

(a) Cardiology

i) In 1984, the acute cardiac care unit (Coronary Care) underwent renovation and the installation of sophisticated computer-based patient care monitoring systems. Coincident with the renovation was the expansion of the unit from ten to twelve beds. The capability of further expansion to fourteen beds is available. About 100 patients per month are admitted to this unit. One-third of the total occurs from hospital transfers from other intensive care units throughout the Maritimes.

ii) Ward 4B (38 bed capacity). In November 1985, a specific service was instituted on this ward, known as the "transfer service". From twenty-five to thirty patients per month are admitted and managed on this specific service. These patients are primarily those whose illness does not allow discharge from their hospital of origin as a consequence of their disability. Admission to this service occurs within one to seven days from the time of contact. The majority of these patients undergo cardiac catheterization and about 50% require either cardiac surgery or coronary angioplasty.

iii) Ward 3B. This unit was designated as a cardiac investigation ward and became operational in January of 1985 with initially an eleven bed capacity. The majority of patient admissions to this ward are short stay, either two or three days, and the bed population is turned over twice weekly. These are patients who require cardiac investigation, primarily cardiac catheterization. As of January 1, 1987, the bed capacity has been increased to fifteen beds and a further increase to seventeen beds will occur by May of 1987.

iv) Cardiac Catheterization Laboratories. Two fully functioning units have been operational since 1977. In the fall of 1985, construction of a new expanded cardiac catheterization suite began. This construction would result in three fully functioning laboratories along with a much larger support facility. Two new cardiac catheterization x-ray systems were purchased and installed, and both units have been fully operational since mid-September of 1986. One of our older systems is now being upgraded and will be moved to the new catheterization suite mid-January of 1987 to be operational by late February of 1987.

(b) Cardiac Surgical Expansion

i) Cardiovascular Intensive Care Unit. In July 1986, renovation of the Cardiovascular Intensive Care Unit began with remodeling and expansion of the existing unit from seven beds to eleven beds. This expansion was complete December 1, 1986 and the new unit has been operational since that time. The average length of stay in this unit following cardiac surgery is two days, and the capacity therefore of this unit is to deal with twenty-two patients weekly.

ii) Three operating rooms at the Victoria General Hospital have been committed for the purpose of cardiac surgery, all functioning simultaneously.

iii) A fourth heart/lung pump is on order for the institution.

The capabilities of the hospital to deal with cardiac and cardiac surgical problems has been substantially increased within the past two years. This expansion has required considerable reconstruction and temporary relocation of facilities, creating considerable stress on the institution and those involved in providing this service. Despite this, the volume of patients undergoing cardiac catheterization in the past year has increased by about 400 (15%), and the number of patients undergoing open-heart surgery has increased by 71 (13.5%). With these structures in place, we anticipate considerably more ease in dealing with further patient volume increases.

2. The increase in capacity as a result of this expansion is (a) cardiac catheterization - 3,600 and (b) cardiac surgery - 700. The operational plan at present for cardiac surgery is 15 cases on average per week for 52 weeks per year. The structural capacity for 1,000 open-heart procedures per year is present.

3. We clearly have the capacity now to meet current and projected requirements in this area for at least the next five years. Plans for further expansion will be dependent on what population base we are dealing with, i.e. Nova Scotia, Prince Edward Island and the majority of New Brunswick, or just Nova Scotia and Prince Edward Island. We are very much in need of guidance from the province of New Brunswick in order to answer this question.

4. An estimate of projected demands for cardiac catheterization and cardiac surgery to the year 2000 is very difficult to make at this time. The number of variables is considerable. The chief variables are related to population base and changing technologies.

(a) Population Base

Statistics Canada projects a Maritime Provinces population in 1995 of 1,843,500 as opposed to 1,706,100 in 1984. The second problem is the impact of aging population. The main effects, which will be thought to occur in the early 1990s, presumably with a higher incidence of heart disease. This, however, may be counterbalanced by the possible continued falling incidence of heart disease, which has decreased steadily since 1967.

(b) Changing Technologies

In the early 1980s, the procedure of coronary angioplasty evolved and it was estimated at that time that approximately 5% of patients undergoing aorto-coronary bypass surgery could be dealt with by this more simple technique. With advances in the technology of angioplasty, about one-third of our patients undergoing revascularization are now being dealt with by angioplasty. With further improvements in equipment and other advances such as the use of laser sources for obstructed vessels, the potential for non-surgical techniques is considerable. Newer developments

with balloon valvuloplasty for stenosed valves also has considerable potential. The balance therefore between non-surgical versus surgical interventions for the future is quite uncertain at this time and may take several further years of evaluation.

With these uncertainties, we believe it appropriate to consider planning on a five year basis only, with regular updating. We project a 20% increase in volumes based on 1986 data and indications for the next five years.

B) WAITING LIST

5. Contact is made by the referring physician to a cardiologist at our institution by phone or by letter and the degree of urgency is determined. The cardiologist accepting the communication makes out an admission form and the form is taken the same day to the Admitting Department. If the patient is determined, for example, to require elective admission, the admission date will be determined by the date that the admission form is made out, i.e. the request for elective admission received on January 7 will precede the admission of the patient whose form was completed on January 8, etc. The time elapsing from referral to placement on the waiting list should be less than 24 hours.

The time elapsing prior to admission for urgent patients will be from one to seven days, semi-urgent patients three weeks and elective catheterizations six weeks. The time elapsing before cardiac surgery in the same categories could range from one day to three months.

At the end of each working week, all patients undergoing cardiac catheterization during that week are reviewed and those requiring semi-urgent and elective surgery are determined. These patients are then presented in a joint conference with the cardiologists and cardiac surgeons at our institution, and their operability as well as degree of priority are determined by joint consensus. Urgent or emergent patients are dealt with on a day to day basis.

6. We would feel that a waiting time of two to three weeks for cardiac investigation for elective problems, and a surgical waiting time of one to two months for elective problems would be ideal. This would translate to a waiting list of about 100 for cardiac catheterization and a surgical waiting list of about 75.

CARDIAC CATHETERIZATION UNIT YEAR 1986-1987

Month	Total Heart Catheterizations	Temporary Pacemaker Insertions	EPS Studies	Coronary Angioplasty	Other	TOTAL
April	172	7	19	5	2	205
May	176	2	16	4	2	200
June	160	13	8	7	3	191
July	154	6		13	3	176
Aug.	131	2	15	12	2	162
Sept.	164	9	10	13		204
Oct.	150	6	13	23	1	193
Nov.	162	5	14	20		201
Dec.	173	6	17	25	1	222
Jan.						
Feb.						
March						
Total this YTD	1442	56	120	122	14	1754
Total last YTD	1257	90	106	6	15	1493
% change (increase) (decrease)	15%	-38%	13%	1933%	-6%	19%

Lillie Hodgson

V.G.H. CARDIAC SURGICAL MORTALITY RATES - 1984

	TOTAL PTS	TOTAL DEATHS	% MORTALITY ALL PTS	% MORTALITY ELECTIVE PTS	COMMENTS
Aorto-coronary bypass surgery	459	18	3.9%	2.3%	Includes reoperations, aneurysm resection, etc.
Aortic valve surgery (replacement or repair)	98	4	3.9%	2.5%	Includes 16 with AC bypass, mitral valve surgery or both at same operation
Mitral valve surgery (replacement or repair)	85	4	4.7%	2.9%	Includes 12 with AC bypass or aortic valve surgery at same operation
Congenital heart lesion	20	0	0	0	

V.G.H. CARDIAC SURGICAL MORTALITY RATES - 1985

SURGICAL PROCEDURE	TOTAL PATIENTS	TOTAL DEATHS	% MORTALITY ALL PATIENTS	% MORTALITY ELECTIVE PATIENTS	COMMENTS
1 Vessel Aorto-coronary Bypass	35	1	2.7%	0%	
2 Vessel Aorto-coronary Bypass	150	4	2.6%	0.7%	
3 Vessel Aorto-coronary Bypass	185	7	3.8%	1.6%	
4 Vessel Aorto-coronary Bypass	59	2	3.4%	0%	
Aortic Valve Replacement	75	5	6.7%	5.3%	19 patients had 1-4 bypass grafts
Mitral Valve Replacement	48	5	11%	0%	Includes acute mitral insufficiency secondary to myocardial infarction
Mitral Valvuloplasty	15	0	0%	0%	3 patients with 1-3 bypass grafts
Congenital Heart Lesions	13	0	0%	0%	3 patients with 1-2 bypass grafts
Left Ventricular Aneurysm Resection	10	0	0%	0%	5 patients had from 2-4 bypass grafts 2 patients had VSD closure 1 patient had VSD closure plus 1 bypass graft 1 patient had mitral valve repair 1 patient had mitral valve plus VSD closure

	AORTO-CORONARY BYPASS SURGERY	AORTIC VALVE SURGERY	MITRAL VALVE SURGERY	CONGENITAL HEART SURGERY	TOTAL EXTRA CORPEAL CIRCULATION
1984					
N.B.	171	33	35	5	223
P.E.I.	24	7	7	3	40
Other	2	1	0	1	5
N.S.	262	57	43	11	357
TOTAL	459	98	85	20	625
1985					
N.B.	149	22	19	6	178
P.E.I.	46	5	5	3	58
Other	1	3	0	0	4
N.S.	278	51	46	10	359
TOTAL	474	81	70	19	599
1986 (to Oct. 1)					
N.B.	150	25	20	3	180
P.E.I.	29	7	7	2	40
Other	2	0	1	1	4
N.S.	237	48	31	10	306
TOTAL	418	80	59	16	530 → 634 Projected 676

Year end

APPENDIX D

Translated Version of Original Letter

Québec City
January 8, 1987

Mrs. Nancy Clark Teed
Minister of Health and
Community Services
P. O. Box 5100
Fredericton, N. B.
E3B 5GB

RE: Cardiological and vascular services offered by the Institut de Cardiologie de Montréal and the Institut de Cardiologie de Québec to New Brunswick residents

Madam Minister:

I trust you will forgive me for the delay in answering your letter of June 11 regarding the above topic. However, I must mention that, since then, my officials and yours, as well as representatives of the Institutes concerned, have met twice and also communicated by telephone. Below are the conclusions which can be drawn from these exchanges.

I am pleased to inform you on this occasion that the Institut de Cardiologie de Montréal and the Institut de Cardiologie de Québec are willing to continue offering New Brunswick residents the services which they now provide. According to the exchanges which have taken place between our representatives, it would seem that these services have been considered very satisfactory.

As things now stand, New Brunswick residents are not subject to longer waiting periods than Québec residents. In emergency cases, measures are taken to ensure patients are transferred as quickly as possible. Naturally, in the event of a reduction in activities at the two institutions concerned, New Brunswick residents, just like Québec residents could expect to suffer the consequences.

.../2

Moreover, the Institut de Cardiologie de Montréal and the Institut de Cardiologie de Québec would be willing to consider the possibility of offering "guaranteed beds" to New Brunswick residents in exchange for some form of compensation. If this possibility were to interest your Department, it would be a good idea to let us know at your earliest convenience, so that a formal agreement between the parties could be planned.

Yours truly,

Thérèse Lavoie-Roux
Minister

GOVERNMENT OF QUEBEC
Minister of Health and Social Services

Translated version of original letter received

Québec City
January 8, 1987

Mrs. Nancy Clark Teed
Minister of Health and
Community Services
P.O. Box 5100
Fredericton, N. B.
E3B 5GB

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Yours truly,

Thérèse Lavoie-Roux
Minister

APPENDIX E

The New Brunswick Medical Society
La Société Médicale Du Nouveau-Brunswick

Founded - Fondée
1867
C.M.A. DIVISION A.M.C.

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SALUS POPULI SUPREMA LEX

January 12, 1987

Dr. J. D. Hatcher
Chairman
Tertiary Care Advisory Committee
Dept. of Health & Community Services
P. O. Box 6000
Fredericton, N.B.
E3B 5H1

Dear Doctor Hatcher:

The New Brunswick Medical Society appreciates the opportunity which we have been afforded to present our views on the subject of tertiary cardiac care for the Province of New Brunswick.

The Medical Society, as a result of an assessment developed at the request of our Board of Directors, has established that the issue of tertiary cardiac care for this Province cannot be considered in isolation. The further development and enhancement of primary and secondary care services for the Province must continue. It was also the view of the Medical Society that the matter of emergency transportation requires significant upgrading if the Province is to enhance its ability to provide an improved quality of medical service.

The Medical Society Board of Directors is also convinced that the bilingual and bicultural nature of the Province must be recognized as an essential element in the creation of a quality service.

We will not take the time of the Tertiary Care Committee to again present the various epidemiological and economic propositions which the Committee has already reviewed. This material was extensively assessed during the development of the policy which we have formulated on behalf of the physicians of the Province. Upon consideration of the information and expert advice available to us, the Board of Directors of the Medical Society wishes to place before the Tertiary Care Committee, the following unanimous recommendation with respect to the subject matter now under consideration by your Committee:

> The New Brunswick Medical Society approves in principle, the development of a cardiac tertiary service in New Brunswick. This approval is contingent upon the upgrading of primary and secondary services throughout the Province, particularly in under-serviced areas, and that the service be available in both official languages; and that current geographical referral patterns be a major consideration.

It is the view of the Medical Society that medical service development in this Province be considered from a global perspective. In this respect, it is our view that a cardiac tertiary service be established but that primary and secondary care be enhanced in a complimentary fashion. Further, as evidenced in our recommendation, the New Brunswick reality requires that this tertiary service be available in both official languages.

On behalf of the Medical Society Board of Directors, I would like to thank the members of the Tertiary Care Advisory Committee for providing us with an opportunity of presenting our view. We wish the Committee every success in their further deliberations.

Yours truly,

Roy V. Cole

Roy V. Cole M.D.
President